DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-09

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
August 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY 01 $ (108,000.)
b. FFY 02 $ (425,000.)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B Page 25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B Page 25

10. SUBJECT OF AMENDMENT:

OUTPATIENT - Transplant

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:

13. TYPED NAME: **Jackie Garner**

14. TITLE: **DIRECTOR**

15. DATE SUBMITTED

16. RETURN TO:

ILLINOIS DEPARTMENT OF PUBLIC AID
201 SOUTH GRAND AVENUE, EAST
SPRINGFIELD, IL. 62763-0001
ATTENTION: John Rupcich

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

19. PLAN APPROVED - ONE COPY ATTACHED

20. EFFECTIVE DATE OF APPROVED MATERIAL

21. SIGNATURE OF REGIONAL OFFICIAL

22. TYPED NAME

23. TITLE

24. REMARKS

FORM HCFA-179 (07-92) *Instructions on Back*

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

payments under Section 1.j. of this attachment, if it is believed that technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification under Section 1.j. of this attachment, and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request or review.

==01/01 l. Notwithstanding the provisions set forth in Chapter I, Section b., Ambulatory Surgical Treatment Centers, the changes described in this Section l., shall be effective January 1, 2001. Payments for hospital outpatient services and ambulatory surgical treatment services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals described in Chapter II.C.8, or children's hospitals described in Chapter II.C.3.

08-01-01 m. Transplant Care

Hospitals performing outpatient adult and pediatric stem cell transplants must be a part of a certified inpatient program and must have been in operation for at least two years with at least twelve outpatient stem cell transplant procedures per year in the past two years. Hospitals must meet the inpatient applicable transplant survival rates as supported by the Kaplan-Meier method or other method accepted by the Department which includes a one-year survival rate of 50 percent for outpatient stem cell transplant patients.

Hospital reimbursement for stem cell transplants provided on an outpatient basis is an all-inclusive rate, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for 50 consecutive days of care which includes a maximum of seven days prior to transplant for infusion of chemotherapy.

The Department will cover outpatient stem cell transplants, provided to United States citizens or aliens permanently residing in the United States under color of law pursuant to 42 U.S.C. 139a(a) and 1396b(v).